Chapter 6 Section 4

Hospital Reimbursement - TRICARE DRG-Based Payment System (Applicability Of The DRG System)

Issue Date: October 8, 1987
Authority: 32 CFR 199.14(a)(1)

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

2.0 ISSUE

What providers and services are to be reimbursed under the TRICARE Diagnosis Related Groups (DRG)-based payment system?

3.0 POLICY

3.1 Areas Affected

The TRICARE DRG-based payment system shall apply to hospital services in the 50 United States, the District of Columbia, and Puerto Rico. The DRG-based payment system shall not be used with regard to services rendered outside the 50 United States, the District of Columbia, or Puerto Rico.

3.1.1 State waivers. Any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs may be exempt from the TRICARE DRG-based payment system under the following circumstances:

3.1.1.1 The following requirements must be met in order for a state to be exempt.

- The state must be exempt from the Medicare Prospective Payment System (PPS);
- The state must request, in writing to TMA, that it be exempt from the TRICARE DRG-based payment system; and
- Payments in the state must continue to be at a level to maintain savings comparable to those which would be achieved under the TRICARE DRG-based payment system. TMA will monitor reimbursement levels in any exempted state to ensure that payment levels there do not exceed those under the TRICARE DRG-based payment

system. If they do exceed that level, TMA will work with the state to resolve the problem. However, if a satisfactory solution cannot be found, TMA will terminate the exemption after due notice has been given to the state.

3.1.1.2 The only state which is exempt is Maryland.

3.2 Services Subject To The DRG-Based Payment System

Unless exempt, all normally covered inpatient hospital services furnished to TRICARE beneficiaries are subject to the TRICARE DRG-based payment system.

3.3 Services Exempt From The DRG-Based Payment System

The following hospital services, even when provided in a hospital subject to the TRICARE DRG-based payment system, are exempt from the TRICARE DRG-based payment system and shall be reimbursed under the appropriate procedures.

3.3.1 Services provided by hospitals exempt from the DRG-based payment system as defined in paragraph 3.6.

3.3.2 All services related to TRICARE covered solid organ transplants for which there is no DRG assignment.

3.3.3 Acquisition costs related to transplants shall be paid on a reasonable cost basis and are not included in the DRG.

3.3.4 All services provided by hospital-based professionals (physicians, psychologists, etc.) which, under normal TRICARE requirements, would be billed by the hospital. This does not include any therapy services (physical, speech, etc.), since these are included in the DRG-based payment. For radiology and pathology services provided by hospital-based physicians, any related non-professional (i.e., technical) component of these services is included in the DRG-based payment and cannot be billed separately. The services of hospital-based professionals which are employed by, or under contract to, a hospital must still be billed by the hospital and must be billed on a participating basis.

3.3.5 Anesthesia services provided by nurse anesthetists. This may be separately billed only when the nurse anesthetist is the primary anesthetist for the case.

Note: As a general rule, TRICARE will only pay for one anesthesia claim per case. When an anesthesiologist is paid for anesthesia services, a nurse anesthetist is not authorized to bill for those same services. Services which support the anesthesiologist in the operating room fall within the DRG allowed amount and are considered to be already included in the facility fee, even if the support services are provided by a nurse anesthetist. Charging for such services is considered an inappropriate billing practice.

3.3.6 All outpatient services related to inpatient stays.

Note: Payment for trauma services (e.g., revenue code 068X), is included in the TRICARE DRG-based payment system.

3.3.7 All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under DRG 481.

3.3.8 All services related to discharges involving children (beneficiary less than 18 years old upon admission) who have been determined to be HIV (Human Immunodeficiency Virus) seropositive.

3.3.9 All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) cystic fibrosis.

3.3.10 For admissions occurring on or after October 1, 1997, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a TRICARE patient who is a hemophiliac. Payment will be made for blood clotting factor when one of the following hemophilia ICD-9-CM diagnosis codes is listed on the claim:

286.0 Congenital Factor VIII Disorder;
286.1 Congenital Factor IX Disorder;
286.2 Congenital Factor XI Deficiency;
286.3 Congenital Deficiency of Other Clotting Factors;
286.4 Von Willebrand's Disease;
286.5 Hemorrhagic Disorder Due to Circulating Anticoagulants; and
286.7 Acquired Coagulation Factor Deficiency.

3.3.10.1 Each unit billed on the hospital claim represents 100 payment units except Q0187, Factor VIIa. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be $1,600 (paid at $0.64/unit - Factor VIII). For HCPCS Q0187, one billing unit represents 1.2mg.

Note: Since the costs of blood clotting factor are reimbursed separately, for these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factor are to be included when calculating the cost-share based on billed charges.

3.3.10.2 Contractors shall make payment for blood clotting factor using Average Sale Price (ASP) plus 6%, using the Medicare Part B Drug Pricing file. The price allows for payment of a furnishing fee and is included in the ASP per unit.

3.4 Hospitals Subject To The TRICARE DRG-Based Payment System

All hospitals within the 50 United States, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

3.5 Substance Use Disorder Rehabilitation Facilities (SUDRFs)

With admissions on or after July 1, 1995, SUDRFs are subject to the DRG-based system.

3.6 The following types of hospitals or units which are exempt from the Medicare PPS, are exempt from the TRICARE DRG-based payment system. In order for hospitals and units which do not participate in Medicare to be exempt from the TRICARE DRG-based payment system, they must meet the same criteria (as determined by the TMA, or designee) as required for exemption from the Medicare PPS as contained in Section 412 of Title 42 CFR.

3.6.1 Hospitals within hospitals.

3.6.2 Psychiatric hospitals.

3.6.3 Rehabilitation hospitals.

3.6.4 Psychiatric and rehabilitation units (distinct parts).

3.6.5 Long-term hospitals.

3.6.6 Sole Community Hospitals (SCHs). Any hospital which has qualified for special treatment under the Medicare PPS as a SCH and has not given up that classification is exempt from the TRICARE DRG-based payment system. For additional information on SCHs, refer to Chapter 14, Section 1.

3.6.7 Christian Science sanitariums.

3.6.8 Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare PPS is exempt from the TRICARE DRG-based payment system.

3.6.9 Hospitals outside the 50 United States, the District of Columbia, and Puerto Rico.

3.6.10 Satellite facilities.

3.7 Hospitals Which Do Not Participate In Medicare

It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE provider. However, any hospital which is subject to the TRICARE DRG-based payment system and which otherwise meets TRICARE requirements but which is not a Medicare-participating provider (having completed a CMS 1561, Health Insurance Benefit Agreement, and a CMS 1514, Hospital Request for Certification in the Medicare/Medicaid Program) must complete a participation agreement (Addendum A) with TMA. By completing the participation agreement, the hospital agrees to participate on all inpatient claims and to accept the TRICARE-determined allowable amount as payment in full for its services. Any hospital which does not participate in Medicare and does not complete a participation agreement with TMA will not be authorized to provide services to program beneficiaries.

3.8 Critical Access Hospitals (CAHs)

Prior to December 1, 2009, CAHs are subject to the DRG-based payment system. For additional information on CAHs, refer to Chapter 15, Section 1.

- END -